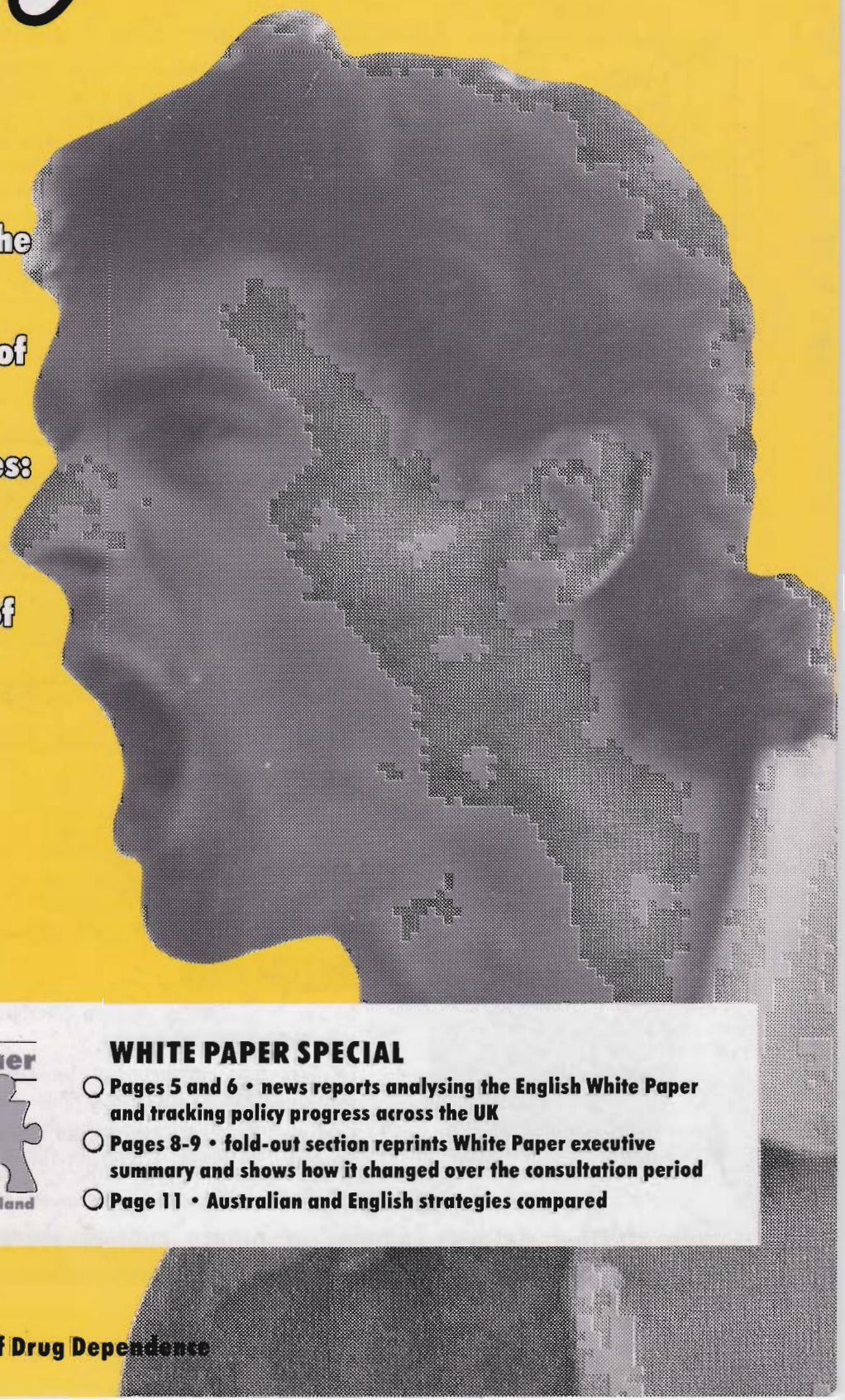
Volume 10 issue 4 • July/August 1995

DRUG links

Why confrontation had to give way to compromise in Britain's therapeutic communities.
See page 12



Tackling Drugs Together

The drug strategy White Paper for England

WHITE PAPER SPECIAL

isdd Institute for the Study of Drug Dependence

DRUG link

DRUGLINK is about 'disapproved' forms of drug use – seen legally, socially and/or medically as 'misuse'. **Druglink** does not aim to cover alcohol and tobacco use. **Druglink** is for all specialist and non-specialist workers and researchers involved in the response to drug misuse in Britain.

ISDD provides Britain's information service on the misuse of drugs and conducts research. **ISDD**'s reference library is unique in Britain and an important international resource. Services include current awareness bulletins, publications and an enquiry service. **ISDD** is an independent charity grant-aided by the Department of Health.

STAFF: Editor: Mike Ashton
Assistant editor: Oswin Baker
Production: Jan Hodgman
Deputy editor: Harry Shapiro
Listings: John Witton

CONTRIBUTIONS: Druglink welcomes letters and other contributions. Send direct or phone Mike Ashton (0171 928 1211) to discuss your ideas.

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isdd
Institute for the Study of Drug Dependence
Waterbridge House
32-36 Loman Street
London SE1 0EE
0171 928 1211

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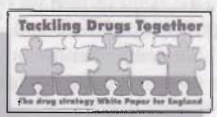
IN THIS ISSUE

Of national strategies and local disruption

Like John McEnroe, you love him or you hate him, but most people will agree that the drugs field is the poorer without him: John Marks, self-styled remnant of the British system bows out from his drugs clinic (page 4) but leaves a barbed legacy in his charge that London doctors killed the British system (page 15). Closure of his unique practice is just one of the many casualties of the health market, disrupting services clients have relied on for years. It's never happened before – the UK now has national drug strategies. If they take hold, they will change your working lives – need we say more? Of course – see panel below for the menu.

ARTICLES



WHITE PAPER SPECIAL

REGULARS

isdd

Ducksville

Webs may be all the rage on ponds, but now may have a deeper historical significance, as ISDD launches a drugs information service on the world wide web. Readers having access to the internet should try the following address

http://www.globalnews.com/isdd/home.html

(no spaces!)

to find our experimental home page. From there they can link to other pages giving

- news (White Paper statement of purpose, compared with Green Paper)
- 'tasters' from ISDD's publications on drug facts, data and trends
- or even a bibliography, with extended abstracts, searchable on-line. Material can be read on-line or printed for off-line use, and the service runs until mid-August (after that, we will be reliant on project or sponsor funding). Thank to the Department of Health for funding so far!

This is an important new initiative for ISDD and, above all, we need to know how we are doing – so we are providing an on-line means of registering (who you are) and giving feedback (suggestions for improvement).

Our corporate plan commits us to improving our electronic competency and our ability to deliver services in these new media, with special attention to information about drug policy-making, criminal justice issues and demand reduction. ISDD is actively involved in the development of drug information in European networks, especially around the new Lisbon-based European Monitoring Centre on Drugs and Drug Addiction – and that involves us in facilitating access to drugs information by UK local agencies, as well.

Those without access to the world wide web, but who can access e-mail, can try out a listserver service – this responds to e-mail by e-mailing back information. To try this, call Toby Seddon on 0171 928 1211 at ISDD, and we'll give you the address (not available at time of going to press).

Rooftop protest as John Marks loses last clinic

When this spring a small hospital trust in an obscure northern town lost its contract to provide a drug clinic, over 70 drug specialists from three continents rushed to petition for the service to be saved. Back in Widnes, patients occupied the building and one staged a prison-style rooftop protest. The heat generated by the loss and that of a similar clinic a year before is fuelling the growth of a national drug users' union.

Why the fuss? The answer is Dr John Marks, champion of the availability of indefinite heroin prescribing for those unable to stop. His embrace of a role as a licensed purveyor of drugs in a state rationing system geared to crime and harm reduction pleased local police and Liverpool's Marks and Spencer, where shoplifting "decreased dramatically" during his spell at the Liverpool clinic.

The admiration was not shared by some fellow doctors who saw prescribing's main role as curing addiction, not maintaining it. Whitehall and Washington are said to have been scandalised[1] by his determination to lever open the medical loophole in prohibition pending the creation of a of a non-medical network of licensees.

Speaking in Liverpool on 30 June, Professor Anthony Henman saw Marks's loss of Widnes as the latest official repression of Liverpool's "experiment" in harm reduction. The experiment was orchestrated by Allan Parry, an ex-addict who ignored red tape to set up a needle exchange in the early '80s and who soon rose to regional drugs/HIV coordinator. He dates the turning point to Britain's acute international embarrassment in 1990 when a DoH official appeared on TV to support the prescribing of smokable cocaine by John Marks. At the time Thatcher's Government was hosting a high profile anti-crack summit.

In practice Dr Marks was more mainstream than his rhetoric. His initial treatment was usually to try to get patients off drugs and to half he prescribed methadone. But his advocacy of heroin maintenance became out of tune with the post-AIDS emphasis on treatment. Had his practice survived it may have chimed more with the new White Paper's crime reduction agenda.

His globally unique approach is now curtailed to a handful of extra-contractual referrals without ever having been thoroughly evaluated (see panel). In future we will have to look to heroin prescribing trials in Switzerland and Australia for their verdicts on an approach indigenous to England.

Page 15: John Marks's farewell

The most recent research on Dr Marks's clinic has never been formally published. It compared similar groups of opiate addicts at three community drug teams, only one of which offered referral to a heroin prescribing doctor, Dr Marks. The others offered mainly oral methadone. Like the only controlled study of heroin v. methadone,[2] this study showed each had benefits.[3]

Twice as many of the addicts on methadone were aiming for abstinence and their physical health was as good as those on heroin. Nearly half the heroin group had used cocaine in the last month compared to just 8 per cent on methadone. This may reflect the freeing up of resources to pay for 'treats' as opposed to 'necessities': just 22 per cent of the heroin group topped up with illicit heroin compared to 70 per cent on methadone. Psychological health measures were consistently better in those on heroin and crime was significantly reduced – probably related to the finding that each spent just £16 a week on illicit drugs compared to £67 among those on methadone.

Countdown to closure

John Marks's greatest impact was in 1985–87 when he ran the large Liverpool clinic on a temporary basis and declined when in 1988 when he returned to Cheshire to run the Warrington and Widnes clinics. In 1994 the local health trust replaced Dr Marks in Warrington. Following official guidance and the desires of the purchaser, the new clinician cut heroin doses and moved patients to methadone.

For the purchaser, North Cheshire Health Authority, the key reason for moving to methadone was that more people could be treated with the same resources (five methadone patients can be treated for the cost of one on heroin) – and even its supporters cannot prove heroin is superior.

With this example before them, patients at Dr Marks's remaining clinic panicked when they heard the same trust and doctor were to take over at Widnes from 1 April 1995. Despite snow, on 3 March a Widnes patient staged a six-hour rooftop protest at the clinic as his addict wife told local press that stopping their heroin would mean reversion to a life of crime ending in prison and their children in care. A week later 20–30 patients occupied the building. The local council condemned the plans and police (not all sympathetic to maintenance) expressed concern over the potential impact on crime.

Speaking to ***Druglink***, one Warrington patient admitted that some less entrenched users appeared to be coping with reduced heroin doses, but said other addicts had reverted to crime and prostitution after years of stability. Some were now injecting dangerous cocktails including temazepam and cyclizine.

She and two others spoken to by ***Druglink*** epitomize the addicts for whom in 1926 Rolleston secured the maintenance option. With around 20 years' heroin use each, their lives had been transformed by Dr Marks. Now in middle age, they were terrified that settled family lives would be devastated by the new regime.

The purchasers stipulated that change at Widnes would be gradual and negotiated with patients, and so far have not seen evidence of major disruption. Easing the transition may have been more support from key workers and in other ways to balance the move away from heroin – staffing Dr Marks would have liked at both his clinics had the resources been available.

For those unable to make the change, the contract says the heroin option will remain, subject to clinical discretion. The experience of at least one Warrington patient proved this to be the case there. After initial reductions, she and her partner were restored to their original doses, but not before they'd endured months when their family life was disrupted as they returned to the streets. With a young daughter, in desperation they sent a solicitor's letter to the trust and enlisted the support of their local MP after an abscess from injecting street drugs – a protest few addicts would have been in a position to mount.

In the long term a European Court ruling in March could reverse methadone's cost advantage as Britain's monopoly heroin processor and packager are forced to face international competition.

Mike Ashton *ISDD*

Better days: John Marks (left) and Allan Parry in the late '80s

1. Henman A. *Drogues légales: l'expérience de Liverpool*. Éditions du Lézard. 1995.
2. Hartnoll R. *et al.* "Evaluation of heroin maintenance in a controlled trial." *Arch. Gen. Psychiat.*: 1980, *37*, p. 877–884.
3. Annual Symposium of the Society for the Study of Addiction, 13 October 1994, and personal communication from Dr Chris McCusker, 19 October 1994.

Tentative moves to recognise social factors

Though the Government maintains there is no evidence that social deprivation causes drug problems, in three places its new White Paper inches closer to recognising a link between drug problems and social factors.

- New to the Cabinet drugs subcommittee is the minister for housing and urban regeneration.
- The Single Regeneration Budget gains a higher profile than in the Green Paper. It aims to promote physical, economic and social regeneration in rundown areas.
- Added to the work programme of the Advisory Council on the Misuse of Drugs is a review of the influence of social and environmental factors on drug misuse.

Bolstering the Government position is the recent report from Professor Michael Rutter, leant on by Tony Newton to parry Liberal criticism that the White Paper ignored the roots of drug problems (see p. 6).[1] Taking a different view is a report from Barnardo's.[2]

Rutter's study of trends in psychosocial disorders over the past 50 years finds that worsening living conditions cannot account for the rising overall level of disorder, since this occurred during periods of rising living standards, for example, the 1950s and '60s.

Though finding no causal link between poverty and disorder, it does concede that increasing inequality in income may be a factor, especially as the formerly affluent descend into poverty.

The inequality theme is taken up by Barnardo's study of how perceptions of society changed over the past 20 years. Its conclusions are strikingly reminiscent of the Scottish drugs task force's argument that "poverty of aspiration" is one of the roots of drug problems, repeated by Liberal spokesman Alan Beith in his criticism of the White Paper.

Barnardo's finds that the rising gap between rich and poor is reflected in health, educational achievement, and behaviour problems. The view that childhood is now worse than for previous generations was shared across the adults interviewed. Barnardo's says it "is all too familiar with the disappointed expectations of parents who see their hopes of a better future for their children thwarted. What is so striking is the way so many who do not share their disadvantage, share their concerns".

Linda Fielding & Mike Ashton *ISDD*

1. Rutter M. *et al eds. Psychosocial disorders in young people: time trends and their causes.* John Wiley, 1995.
2. Barnardo's. *The Facts of life – the changing face of childhood.* 1995

Strategic progress uneven across UK

Page 6: English drug strategy goes live

A bird's eye view of the development of drug strategies across the UK shows Scotland sprinting ahead, aided by the fact that its plan was finalised last October[1] when England's was published for consultation.

Scotland's 15 drug actions teams met for the first time in May and members of its national coordinating committee, the Scottish Advisory Committee on Drug Misuse, should already be on first-name terms. One of the first tasks of the Scottish drug action teams will be to spend the over £33,000 each was allocated for 1995–96 to employ a development officer.[2] In the same year health board allocations for drug services nearly tripled to £6.8 million. Part of the increase is a diversion of £1.69 million from HIV funding, reflecting concern that funding tied to HIV leaves drug services vulnerable to fluctuations in the priority given to fighting the virus.

Scotland's drug service funding is now remarkably close to the £11.6 million allocated for England.[3] However, at £11.5 million England's drug-related HIV funding for 1995–96 is four times that of Scotland.

Despite modifications, the final English strategy is "still in stark contrast" to the Scottish version, said the Scottish Drugs Forum. The main difference is Scotland's newfound enthusiasm for harm reduction, evidenced in March when a worker took up post at the Scottish Drugs Forum to develop and implement safer dancing guidelines, a project funded for at least 18 months by the Scottish Office.

By the end of June Wales had yet to issue its draft drug and alcohol strategy for consultation, though on 6 June a Welsh Office minister had promised it "in the next few weeks". The same minister had previously "hoped" for publication in April. Distinctive to Wales is the unified approach to alcohol and drugs, signified in plans for a joint strategy and a Welsh Office Drug and Alcohol Unit.

In Northern Ireland peace has reportedly brought an upsurge in recreational drug use[4] though signs of an increase were there well before the cease-fires.[5] Loyalist paramilitaries in particular are said to have diverted to the drugs trade, as on the control side have their old adversaries, the Special Branch. Ulster Volunteer Force leaders were so concerned at the dealers in their midst that in May they were the main movers behind a Combined Loyalist Military Command drugs purge.

Despite its historically low rate of drug problems, Northern Ireland's Committee on Drug Misuse stole a march on Wales with the publication in March of a draft drug misuse policy.[6] The consultation period ended on 31 May after which they will make recommendations to the N. Ireland Dept. of Health and Social Services.

The draft Ulster strategy is closely modelled on England's, though nuanced for the Irish situation. With a small population and more integrated statutory services, local drug action teams are not proposed as a basis for local coordination, a role played for the province as a whole by its Committee on Drug Misuse.

England is behind Scotland but ahead of the rest of the UK with its policy finalised and approved by government in May and now being implemented (see page 6).

National coordination

An interesting feature of the emerging strategies across the UK is the way they handle national coordination. In England the role is filled largely by the Central Drugs Coordination Unit, a small group of civil servants in the Privy Council Office. Though they have learnt quickly, CDCU Director Sue Street and her staff were specifically recruited to be new to work in the drugs field.

In the rest of the UK groups of established drug experts are being integrated into government policy-making to provide for the national oversight supplied in England by the CDCU. Closest to the CDCU model is Wales, though even there the Welsh Office says its Drug and Alcohol Unit will consist of "professionally qualified staff with experience of treatment and prevention work".

In Scotland and N. Ireland, the national role is played by arms-length committees of outside experts and representatives of government and statutory services. Though linked closely to government, the experts on these committees retain an independent role and are not civil servants.

Perhaps partly accounting for these differences is the fragmentation of English government departments, making coordination *within* government more of a priority then in the rest of the UK. A small group of insiders at the departmentally neutral Privy Council Office, backed by the political clout of Privy Council President Tony Newton, stood more chance of achieving this than outside experts not privy to departmental sensitivities.

Mike Ashton *ISDD*

1. Scottish Office Ministerial Drugs Task Force. *Drugs in Scotland: meeting the challenge*. Scottish Home and Health Department, 1994.
2. *SDF Bulletin*: June 1995.
3. *Druglink*: January/February 1995. Includes £2.786m for methadone prescribing.
4. McKittrick D. *The Independent on Sunday*: 7 May 1995.
5. Connolly P. *Newsletter* (Belfast): 20 May 1995.
6. Northern Ireland Committee on Drug Misuse. *Drug misuse in N.Ireland: a draft policy statement*. March 1995.

❑ **The Department of Health has distributed an information pack on sexual health promotion among drug users based on a study at the Centre for Research on Drugs and Health Behaviour.[1] Health minister John Bowis says it is "part of the department's [White Paper] commitment to continue to encourage a range of harm reduction initiatives aimed at drug misusers" and that its messages are the same as for the general population. The pack is aimed at anyone who works with drug users and can supply safer sex education.**

1. Green A. and Rhodes T. *Sexual health promotion with drug users.* Centre for Research ... and AVERT, 1995. Available from AVERT, phone 01403 210202, price £5.

❑ In the Commons on 10 May Tony Newton announced "immediate steps" to curb temazepam misuse through safe custody controls on manufacturers and wholesalers. Also to start immediately, he said, are legally required consultations to ban prescription of the gel-filled capsules linked to serious physical damage. However, by the end of May one of Britains's largest temazepam manufacturers and the pharmaceutical industries' association had yet to be approached.[1] Less welcome was Mr Newton's statement that Government is still "carefully considering" the call from the ACMD in November 1992 to make temazepam possession an offence.

1. *Scotsman*: 2 June 1995.

❑ **Another US study has concluded that "alcohol and drug treatment services pay off big in less crime, lower medical costs and significant overall tax savings", announced Oregon's director of drug treatment on 26 April.[1] The Oregon study follows those in California and of US cocaine treatment which found that treatment pays for itself seven times over.[2] The Oregon researchers have yet to quantify total savings to the public purse but calculate savings of $14 million a year to the criminal justice system alone from reduced arrests and imprisonment.**

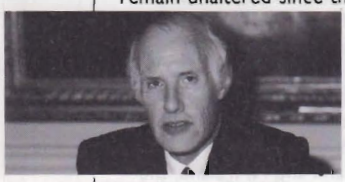
1. Oregon Department of Human Resources. News release, 26 April 1995.

English national strategy goes live

Opposite: White Paper's foreword and summary. Page 5: what the strategy says about social factors; stategies across the UK

On 10 May the English drug strategy White Paper *Tackling Drugs Together*[1] was launched by Privy Council President Tony Newton with "accessible treatment" added to its most important passage, the statement of purpose.

The focus on demand/crime reduction and most of the details remain unaltered since the Green Paper last October. Several updates simply record spending decisions made in the interim. The substantial changes confirm the reputation for listening gained by Mr Newton and his Central Drugs Coordination Unit (CDCU) in the run-up to the Green Paper.



Tony Newton: reputation for listening

If the policy takes hold, services – especially those funded from statutory sources – will no longer be able to argue for funding purely on a client-centred agenda of responding to drug users' needs, but will have to show their relevance to national objectives which focus on primary prevention, abstinence and crime reduction.

With a general election due during the three years of the strategy, interest centred on Labour's response. The implication was clear: as things stand, Labour would continue the policy. Cross-party support was sustained in the White Paper debate a month later. Just a few ripples mainly from the Liberal Democrat benches disturbed the unaccustomed consensus of a Commons keen to show its support.

Quoting the equivalent Scottish report, Liberal spokesman Alan Beith said the policy failed to address the fundamental causes of the drug problem in "deprivation, alienation and poverty of aspiration".[2] Parrying, Tony Newton cited the less than clear-cut findings of Sir Michael Rutter's study of psychological disorders in young people (see *Tentative move to recognise social factors* on page 5).

Fine-tuning welcomed

Most observers will welcome the changes made to the Green Paper. Among them is a commitment to retain the CDCU until March 1996 to help implement and monitor the strategy. On 10 May Tony Newton heavily hinted that the unit can also look forward to a life beyond March. In the immediate future CDCU staff will be taking a close interest in the development of drug action teams, visiting each health district by the end of 1995 to see if the plans are working.

Including "accessible treatment" in the agenda-setting statement of purpose is intended to show a commitment to this sector widely seen as lacking in the Green Paper. This commitment is bolstered by an expanded list of tasks which now includes a plan to use the Department of Health's Effectiveness Review as a basis for guidance to treatment purchasers and a commitment to follow up the Social Services Inspectorate's critical report on community care.

At the time of the Green Paper some quipped that the CDCU's spell-checker must have been programmed to replace 'harm reduction' or 'harm minimisation' by terms which could not be read as back door liberalisation. After some agonised and extensive discussions in the cabinet drug misuse subcommittee, those terms now appear in the White Paper, guarded by quote marks to show they remain outside the government's preferred vocabulary.

Their inclusion signifies a considerable shift since the Green Paper. The ministers' problem was not over measures such as needle exchanges for regular and older users. Policy on this is essentially unaltered, stressing the need for responsible disposal of used works.

Where ministers had to swallow hard was over harm reduction for younger recreational users. Responding to concern over rave-related ecstasy deaths, they called for clubs to take "responsible measures" to "save lives" such as providing free cold drinking water. Alan Beith complained they had drawn the line at promoting chill-out rooms because this "would appear to condone drugtaking".

> It could mean a move away from client-centred services

The Government's concession was hedged with reminders that it "places a very strong emphasis on preventing young people from misusing drugs" and is opposed to anything which "could be interpreted as explicitly condoning drug misuse" or which understates the legal or health risks. With these provisos, the chances are slim for a harm reduction leaflet seeking official support on the basis of a one-line aside that drugs are illegal and never totally safe.

As well as to reduce health risks, services may also justify harm reduction under the crime reduction umbrella. Though de-emphasised, harm reduction is still alive in England; it's just that its clothes may need to be trimmed or adjusted.

As soon as the Green Paper was launched it was clear that omission of social services from drug action teams was a mistake, one the White Paper duly rectified. Discretion to co-opt additional members and encouragement that one of these should come from the voluntary sector help plug another much commented-on gap. Tony Newton refused to extend similar encouragement to elected local councillors, though these might get in as co-opted members.

Pleas that basing drug action team areas on health districts would make it impossible for some senior officers to attend helped persuade ministers to make districts first choice, but then to allow local flexibility as long as there are no gaps. This could mean two or more health authorities participating in a single team and pooling the money given to each to fund a team's development.

Concerns remain

With little changed between the two, many of the criticisms made of Green Paper will be made of its successor. Top of the list is resourcing. Tony Newton was able to identify an extra £13 million for 1995–96 to implement the White Paper, but could not confirm that it was all 'new' as opposed to redirected money.

This government contribution is intended to support spending of just under £2 million for the first half-year of the drug action teams,[3] £5.9m for education, £1m for young people's services, and £4.6m for prison drug testing and treatment programmes. The opposition seemed unimpressed as did Tory MP Tim Rathbone, chair of the All Party Drugs Misuse Group.

For Tony Newton and the CDCU the strategy is more about making the most of the estimated £526m already spent on drugs.[4] Efficiency savings from better information and evaluation, and the synergy of effort as previously uncoordinated services start pulling together, are expected to deliver the resources to make the strategy a reality. In schools, local and health authorities, police and prisons, the pressure on resources is such that this ambition is being seriously questioned, among others by SCODA and the Local Government Drugs Forum (LGDF).

LGDF calculates that if elements of the policy such as arrest referral succeed, this alone may place an extra load on community care budgets of over £6m a year. With ringfencing of these budgets ending next March, "there can be minimal optimism that support for these services will expand" and tight local authority funding settlements could lead to cuts, warns LGDF.

The White Paper gives no sign of responding to calls for efficiency reviews of enforcement and prevention such as that being undertaken for treatment, nor of diverting some of the £346m spent on enforcement to shore up treatment and prevention. SCODA's director Roger Howard warns that flexible responses will be seriously blocked by the lack of a mechanism for treatment and prevention to be subsidised by criminal justice sources, despite the fact that these stand to make savings through initiatives such as treatment alternatives to custody or prosecution.

What next?

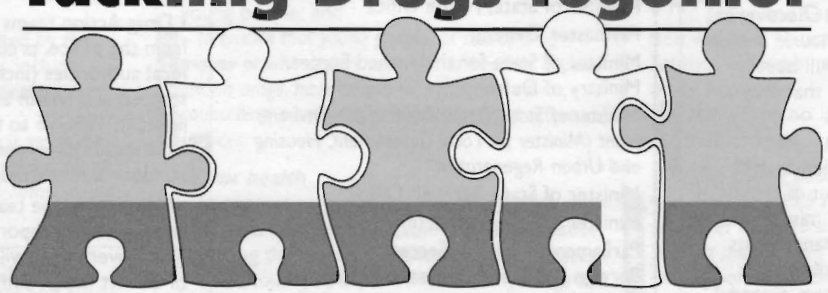
Already the CDCU and policy insiders at the Department of Health are looking ahead to 1998 when the three-year strategy comes up for renewal. Treatment improvements and prevention programmes building up from primary school level will even then be a long way from having proved themselves. What's widely seen as inadequate funding for the strategy is unlikely to dramatically increase over the next three years, further limiting the impact. On the other side is a seemingly inexorable rise in drug misuse drug dating from the '50s which the strategy is unlikely to turn back. The aim instead is containment.

With this background the scenario for 1998 is predictable. Indicators of drug misuse are likely to have increased despite the new coordination structures. That would leave a choice of declaring the policy a success because without it things would have been worse, a failure because the tide has not been turned, or a promising venture in need of adjustment or a greater impetus.

Like the proverbial decision over whether the glass is half full, this choice will be determined as much by what the decision-makers want to see as by any scientific calculation. **Mike Ashton** *ISDD*

1. *Tackling drugs together: a strategy for England 1995–1998*. HMSO, 1995.
2. *Hansard*: 9 June 1995.
3. Over the three years of the strategy funding totals £8.8 million. In the 2nd and 3rd years health authorities receive £33,000 per full year for the teams, the same as in Scotland.
4. Estimate is for 1993–94.

Tackling Drugs Together



The drug strategy White Paper for England

OVERLEAF *Druglink*'s reprint of the White Paper's foreword and executive summary

On 10 May 1995 it happened – England had an operational drug strategy that was more than a repackaging of the agendas of government departments and statutory agencies. Joined through national and local coordinating structures, for at least the next three years these varying agendas are to be harnessed to the common set of national objectives set out in the Tackling Drugs Together *White Paper. Overleaf is* Druglink*'s reprint of the White Paper's foreword and executive summary, showing where these differ from the draft strategy issued last October. On page 6 our news report explores what these differences mean and the prospects for the next three years.*

Executive summary

AIMS OF THE NEW STRATEGY

The Government is introducing a new strategy for the period 1995–98 to tackle drug misuse. While fully maintaining the emphasis on law enforcement and reducing supply, the strategy recognises the need for stronger action on reducing the demand for illegal drugs. The strategy will apply to England only; separate action is under way in Scotland, Wales and Northern Ireland that will be consistent with what is proposed for England, but will be tailored to the particular needs of those countries.

Illegal drugs are those controlled by the Misuse of Drugs Act 1971. These include heroin, cocaine, amphetamines, ecstasy and cannabis.

The focus of the new strategy is on three areas: crime; young people; and public health. The strategy is driven by the following Statement of Purpose:

> NEW To take effective action by vigorous law enforcement, *accessible treatment* and a new emphasis on education and prevention to:
> • increase the safety of communities from drug-related crime;
> • reduce the acceptability and availability of drugs to young people; and
> NEW • reduce the health risks and other damage *related to* [caused by] drug misuse.

Multi-agency coordination, both at national and local levels, will be required in order to make systematic progress towards these aims.

OBJECTIVES

The Government's main objectives in these three areas are:

Crime

– to see that the law is effectively enforced, especially against those involved in the supply and trafficking of illegal drugs;
– to reduce the incidence of drug-related crime;
– to reduce the public's fear of drug-related crime; and
– to reduce the level of drug misuse in prisons.

Young people

– to discourage young people from taking drugs;
– to ensure that schools offer effective programmes of drug education, giving pupils the facts, warning them of the risks, *and helping them to develop the skills and attitudes to resist drug misuse*;
– to raise awareness among school staff, governors and parents of the issues associated with drug misuse and young people;
– to develop effective *national and local* public education strategies focusing particularly on young people; and
– *to ensure that young people, at risk of drug misuse or who experiment with or become dependent on drugs, have access to a range of advice, counselling, treatment, rehabilitation and aftercare services.*

Public health

– to protect communities from the health risks and other damage associated with drug misuse, including the spread of communicable diseases;
– to discourage people from misusing drugs and to enable those who do so to stop;
– to ensure that individual drug misusers have access to a range of advice, counselling, treatment, rehabilitation and aftercare services; and
– *to ensure that families of drug misusers have access to advice, counselling and support services.*

PLANS FOR ACTION

The main proposals for action in support of these objectives are:

Increasing community safety from drug-related crime

• In the short term, the police, Customs, probation and prison services will be asked to consider what changes in their operational arrangements they wish to make in the light of the Statement of Purpose and report the results by *September* [June] 1995.
• The police, probation and prison services will be asked to develop explicit strategies for tackling drug misuse, including appropriate training and participation in local multi-agency partnerships, by March 1996.
• One of the Home Secretary's five key objectives for policing is to target and prevent crimes which are a particular local problem, including drug-related criminality, in partnership with the public and other local agencies. HM Inspectorate of Constabulary will examine all police force drug strategies by the end of June 1996, to ensure that they are consistent with the key objectives.
• HM Prison Service will include the reduction of drug misuse in prisons as a key performance indicator. Mandatory drug testing, improved security (for example, using dogs to check for drugs) and effective treatment services will be among the measures introduced.
• The police and Customs services, in conjunction with the National Criminal Intelligence Service, will work to improve liaison on operational matters.
• There will be no legalisation of any currently controlled drugs.

Helping young people to resist drugs

NEW • *An additional £5.9 million will be available to schools in 1995-96 under the Grants for Education Support and Training programme to train teachers and support innovative projects in drug education and drug prevention.*
• Schools will be asked to develop their policies on managing drug-related incidents and drug education by the start of the spring term 1996, in the light of guidance from the DfE.
• The Office for Standards in Education will inspect the quality and effectiveness of schools' policies on drug education and the management of drug-related incidents.
• New interdepartmental publicity campaigns coordinated by the Department of Health and involving private sector organisations with advertising and media expertise, and role models, will be aimed at motivating young people to resist drug misuse.
NEW • *The Department of Health will make £1 million available in 1995-96 to stimulate the development of services to address the needs of young people at risk of being drawn into drug taking or those at an early stage of drug misuse.* Further guidance on early intervention services will be issued in the light of the current review of effective treatment and services for drug misusers.
• The Home Office Drugs Prevention Initiative will expand in 1995 to develop drug prevention work with young people and local communities over a wider area and covering more people.

Foreword

This White Paper is the Government's new drugs strategy for England. It is a revised version of the Green Paper, *Tackling Drugs Together*, issued for consultation in October 1994.

NEW *The Government is committed to reducing both the supply of illegal drugs and the demand for them through a wide range of action and programmes. We are also committed to reducing the prevalence and incidence of drug misuse. To do this, we need the help of many organisations and individuals. Those in the voluntary and private sectors, local authorities, schools, parents, health professionals and the criminal justice agencies have a crucial role to play.*

The new strategy will be driven by the following Statement of Purpose ... (see above). NEW *These elements* [of the statement] *are all of equal importance.* They are interdependent and we are addressing them together. NEW *Tackling drug misuse is a long-term process. Nonetheless, it is the Government's view that systematic progress towards these priorities by 1998 would address the areas of greatest current concern.*

The main developments of the Green Paper's proposals are:

NEW • *strengthening the plans for local action by providing over £8.8 million over the next three years for Drug action teams, including social services directors on the teams, encouraging the teams to co-opt representatives from the voluntary sector and suggesting more flexible geographical boundaries;*
NEW • *reinforcing the commitment to reduce the health risks of drug misuse by referring explicitly to accessible treatment in the Statement of Purpose and clarifying the Government's position on 'harm minimisation';*
NEW • *enhancing consistency in tackling drug-related crime by a shared definition and developing complementary performance measures for police and Customs including targets to dismantle major drug trafficking organisations; and*
NEW • *confirming the priority of helping young people to resist drugs by supporting expenditure of £5.9 million in 1995–96 for drug education in schools, providing £1 million in 1995–96 for services for young people at an early stage of drug misuse, and making action against drugs a specific objective for grants to youth services.*

Each of us is personally committed to this strategy and *determined to lead our Departments towards achieving its demanding objectives. We look forward to working in partnership with others who are ready to contribute their efforts to tackle drugs together.*

The Rt Hon Tony Newton OBE MP, Lord President of the Council and Leader of the House of Commons
The Rt Hon Michael Howard QC MP, Secretary of State for the Home Department
The Rt Hon Virginia Bottomley JP MP, Secretary of State for Health
The Rt Hon Gillian Shephard MP, Secretary of State for Education
David Heathcoat-Amory MP, The Paymaster General

A new government drug strategy for England

Reducing the health risks of drug misuse

• There will be a national helpline from April 1995 to provide support and advice on drug misuse.

• Treatment policies will be in line with the overall priorities of the national strategy. Their principal objective will be to assist drug misusers to achieve and maintain a drug free state.

• Whilst abstinence remains the ultimate aim, steps will continue to be taken to reduce the spread of HIV and other communicable diseases by drug misusers.

NEW • In the light of the findings of the Effectiveness Review *and consideration of any resource implications*, the Department of Health will issue guidance to purchasers to ensure that drug misusers have easy access to cost-effective and appropriate services.

• There will be special consideration by HM Prison Service and the Department of Health of the provision of services for drug misusers in prisons [and appropriate local arrangements for purchasing drug service provided in the community for people diverted from custody].

NATIONAL ARRANGEMENTS

DRUG *links* National coordination arrangements are given a higher profile in the executive summary of the White Paper by dealing with them in a separate section, including the full membership of the Ministerial Sub-Committee of the Cabinet on the Misuse of Drugs, and adding a passage emphasising the role of the Advisory Council on the Misuse of Drugs, previously mentioned only briefly as one of a number of sources of information and research. However, much of this material was in the body of the Green Paper so we have only marked passages which differ from the Green Paper as a whole.

NEW At national level, coordination between those Departments involved in tackling drug misuse *is being* [must be] improved. This will be achieved by the new strategic framework and by the existing Ministerial Sub-Committee of the Cabinet on the Misuse of Drugs, which involves Ministers from all interested Departments (see below). The Lord President of the Council chairs the Sub-Committee and is supported in his coordinating role by the Central Drugs Coordination Unit. *The Unit will remain in place until March 1996 when its role, for the life of the strategy, will be reviewed.*

NEW

Ministerial Sub-Committee of the Cabinet on the Misuse of Drugs

The composition of the Committee is as follows:

Lord President of the Council (chairman)
Solicitor General
Minister of State, Home Office
Paymaster General
Minister of State for the Armed Forces, Ministry of Defence
NEW *Minister of State, Department of the Environment (Minister for Local Government, Housing and Urban Regeneration)*
Minister of State, Scottish Office
Minister of State, Department for Education
Parliamentary Under-Secretary of State, Foreign and Commonwealth Office
Parliamentary Under-Secretary of State, Department of Health
Parliamentary Under-Secretary of State, Welsh Office

Others, including the Minister for Overseas Development and the Parliamentary Under-Secretary of State, Dept. of Employment, may be invited to attend as appropriate.

TERMS OF REFERENCE: To coordinate the government's national and international policies for tackling drug misuse, and report as necessary to the Ministerial Committee on Home and Social Affairs.

Independent advice to Government is provided by the Advisory Council on the Misuse of Drugs (see below). Its current work programme includes the problems of drugs in prisons *and the influence of wider social and environmental factors on drug misuse*. An important new commitment is to advise on the Government's research strategy in the light of the Statement of Purpose, objectives and tasks in this White Paper.

NEW

The Advisory Council on the Misuse of Drugs

The Advisory Council on the Misuse of Drugs (ACMD) was established under the Misuse of Drugs Act 1971. Its terms of reference, as set out by the 1971 Act, are:

"to keep under review the situation in the United Kingdom with respect to drugs which are being or appear to them likely to be misused and of which the misuse is having or appears to them capable of having harmful effects sufficient to constitute a social problem"; and to advise Ministers on measures to be taken.

ACMD currently has 36 members comprising academic experts and professional practitioners in the area of drug misuse.

Much of ACMD's work is carried out by its committees and working groups. Recent reports have covered AIDS, drug education in schools, and drug misusers and the criminal justice system. Such reports are highly respected for their authority and play an important part in developing Government policy.

LOCAL ARRANGEMENTS

A national strategy can only work if it is delivered effectively on the ground. Much excellent work is already being carried out locally by agencies and individuals to tackle the drugs problem. The Government particularly supports initiatives where different agencies work in partnership. The Government wishes to build on existing successes so that there is effective local action throughout England.

The main proposals for action over the next three years are:

• Drug Action teams of senior representatives from the police, probation and prison services, local authorities (including education *and social services*) and health authorities will be established in 1995-96 to tackle drug-related problems locally. NEW *Co-option of voluntary sector representation is encouraged.*

• Members of the team will select their own chair, who will report to central government. The Government will call upon chief executives of district health authorities to set up the Teams [one in each district]. NEW *There will be some flexibility on the selection of geographical boundaries for the drug action teams as long as all parts of England are covered.*

• The team's role will be to make progress in line with the overall priorities of the national drugs strategy and in the light of local needs.

DRUG *links* The next paragraph is more detailed then in the Green Paper's executive summary. The marked passage shows where it appears to signify a change in emphasis from the Green Paper as a whole.

NEW • Drug reference groups will be established *to provide a source of local expertise to the drug action teams* and to harness local communities in action to tackle drug misuse. Membership will include, for example, voluntary and statutory service providers, drug service users, doctors, school governors and local business interests.

NEW • *The Government plans to make available over £8.8 million in development funds to support the Teams over the three years of the strategy.* Each service represented on the team will be accountable through its own management line for deploying its resources for tackling drug misuse and cooperating with other agencies.

DRUG *links* Two sections previously at the end of the executive summary of the Green Paper have been deleted.

• Deletion of the section on monitoring progress reflects the fact that the White Paper no longer has a chapter devoted to this topic. Instead it is dealt with throughout the report under the appropriate chapter, eg, measures to monitor progress on reducing health risks are in the health risks chapter. The main significant change is that the Green Paper's proposal to supplement key performance indicators "through a system of detailed performance indicators" has been deleted, leaving only the key indicators in the White Paper.

• Deletion of the section on coordination and information largely reflects the fact that the White Paper no longer has a chapter devoted to this topic, rather than a retreat from the Green Paper's proposals, most of which are retained.

Tackling Drugs Together

Foreword and executive summary

Reprinted here are the foreword and executive summary of *Tackling Drugs Together*, showing where these differ from the Green Paper issued for consultation last October. *Italicised* passages marked in the margin as NEW are not only new to the White Paper, but also appear to represent a change in policy or emphasis. In a few places square brackets [ ] indicate passages replaced by new text. Tint panels are explanatory comments from *Druglink*.

England v. Australia

Despite coming ten years before England's, to many Australia's drug abuse policy will seem more progressive, but this comparison of the two also reveals some important strengths in the English approach.

TWO YEARS AFTER Australia's National Campaign against Drug Abuse was launched in April 1985, Dr Neil Blewett, the Minister of Health responsible for its oversight, described its assumptions, arguments and aspirations."[1] While it would be wrong to assume Australia had no drug abuse policy before 1985, or that England only acquired one with the publication of *Tackling Drugs Together* in 1995, nonetheless the two statements present an interesting comparison, separated as they are by a decade.

Both recognise the inter-relatedness of the measures needed to address the problems and both propose a coordinating mechanism with an approach straddling government departments. Where *Tackling Drugs Together* represents an advance on the Australian equivalent is in its adoption of clear objectives and performance indicators. Australia's original campaign document[2] expressed its objectives in fairly general terms; only with the publication of the *National Drug Strategy* in 1993 were indices of effectiveness identified.[3]

A harm reduction campaign

Despite the militaristic rhetoric of the term 'campaign', from the start Australia took the view that minimisation of drug-related harm was the only realistic objective of a national campaign, a view which has been consistently maintained. Given its head start, not surprisingly Australia's policy has evolved in several directions. There are, for example, policy documents and strategies for methadone, tobacco, alcohol, amphetamines and cocaine. But all subscribe to the minimisation of harm objective.

Judging by the responses to the Green Paper which preceded *Tackling Drugs Together* and the changes made to that draft, at national policy level England has been slow to recognise that while we may be able to minimise the harm from drug abuse, in all probability drug abuse itself cannot be eliminated. The pointed omission of reference to harm minimisation in the Green Paper and its only tentative inclusion in the White Paper (which insists that the ultimate objective must be abstinence) suggests that for England this objective is still controversial.

> Australia saw harm minimisation as the only realistic objective

In the evolution of England's policy it seems that at first more faith was placed in the role of enforcement in controlling the supply of drugs, with demand-reducing strategies making a belated appearance. By contrast, from the start Australian policy sought to address both supply and demand. As Neil Blewett observed:

"There are those who would focus attention on the supply side and find all solutions to the drug problem therein, but to restrict supply and do nothing about demand would simply exacerbate social problems arising from drug use. On the other hand, to deal simply with moderating demand and to neglect supply will ignore the very demand imperatives created by the suppliers".

A marked difference between the two policy statements is in their preparedness to entertain changes in the legal status of drugs. In the Home Office's press release issued with *Tackling Drugs Together*, the Home Secretary says "All drugs now banned by law will stay banned by law". In contrast, Australian policy has allowed for legal reforms. Possessing small amounts of cannabis for personal use has been decriminalised in two jurisdictions, and consideration is being given to the feasibility of a heroin prescribing trial in the Australian Capital Territory (this may seem old hat to England but in Australia heroin is currently a fully prohibited substance). One of the advantages of a federated country is the opportunity to experiment with drug policies and monitor their effects before nationwide application.

Fail to address social conditions

The two policies share a rather naive belief in the effectiveness of education as a means of persuading young people not to use drugs. Education about the effects of drugs must be part of any coherent campaign, but a campaign which assumes that simply providing people with information about drugs will mean they resist their use, or use them in a more discerning way, is bound to fail, precisely because it does not address the reasons why people use drugs.

As a British commentator has pointed out, if social and economic conditions are not addressed, "no amount of committee reports, customs officers, sniffer dogs, life sentences, consultant sessions, or lecturing to schoolchildren, will be able to pick up the pieces".[4] Only when governments acknowledge the relevance of social and economic conditions to the uptake of drugs, and seek to address these conditions, will the extent of drug use and the harm associated with that use be reduced, if not eliminated.[5]

from
David Hawks
Director of the National Centre for Research into the Prevention of Drug Abuse in Perth, Australia.

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DRUG link
PHOTOCOPIABLE FACTSHEET

INFORMATION FOR DRUG WORKERS FROM ISDD

14 DRUG TERMS: TWO

This is the second of two factsheets on definitions of commonly-used words in the drug field. The first sheet outlines the more general words and this sheet picks up on the more specialist ones. Both sheets can be used when training new staff, explaining things to the media or as a quick reference point when you're unsure on the specifics of certain terms.

The Advisory Council on the Misuse of Drugs (ACMD) was set up under the Misuse of Drugs Act 1971 to advise the government on drug misuse policy and on amending the Act and its regulations.

Community Drug Team (CDT) is a statutory drug agency, working at a local level both to help drug users and to educate the community. Offer a range of services similar to street agencies, but not always a drop-in service.

Community safety is a combination of crime prevention, victim support and tackling the fear of crime. Community safety is developed by local authorities working in partnership with the police, probation services, the voluntary sector and community groups.

Decriminalisation/legalisation; *decriminalisation* is effectively the more 'neutral' of the two terms. It refers to removing references to drugs (usually those referring to possession) from criminal law. *Legalisation* means allowing drugs to become commercial products, and may involve setting up a licensing system (ie, putting drugs on a par with alcohol).

Demand reduction occupies the middle ground between ***harm reduction*** and ***supply reduction***, this term describes policies and programmes aimed at reducing consumer demand for drugs. It can take in educational, treatment and rehabilitation strategies.

Drug Action Team (DAT) is a recent government proposal for ensuring effective delivery of the national drug strategy on the local level. *DATs* will be made up of senior representatives from health and local authorities and the criminal justice agencies.

Drug Dependency Unit (DDU) is a statutory service usually hospital based offering a range of services including out-patient methadone prescribing, in-patient detoxification, counselling etc.

Drug Misuse Database (DMD)/ regional database; piloted by the North Western Regional Health Authority in 1987, the *DMDs/regional databases* stand alongside the Home Office's ***register of addicts***. Their advantages over the 'register' are that they cover both a wider range of services and a wider range of drugs. As they are regionally-centred, the *DMDs* also provide a much more nationally comprehensive picture than any other comparable set of data.

Harm reduction/minimisation are policies and programmes aimed at reducing the risks of drugs and drug using to individuals and society. This can range from advice on safer drug use to community action programmes. [*See* ***Demand reduction*** *and* ***Supply reduction***]

Illegal/illicit are two words are often used interchangeably to describe drugs and drug-taking behaviour. There is a slight difference however: *illegal* means prohibited by law, while *illicit* is a wider term, taking in actions which offend against common codes of accepted behaviour.

Legalisation [see ***Decriminalisation***]

Maintenance therapy is the treatment of drug dependence by prescribing a substitute drug for which 'cross-tolerance' exists. The goal is to reduce the use of a particular drug or to reduce the harm caused by a particular method of administration. The most well-known form of *maintenance* therapy is the prescribing of methadone to wean people off opioids.

Minnesota Model [*See* ***Twelve-step programme/group/method***]

Needle Exchange Schemes are services either offered by a drugs agency or a pharmacy whereby users can obtain free syringes and needles in exchange for used injecting equipment

Notifiable drugs, users of these should be notified by their doctor to the Home Office. There are 14 notifiable drugs including cocaine and various opioids. [*See* ***Register of addicts***]

Notified addict is a user of ***notifiable drugs*** who is officially recorded on the ***register of addicts***.

Outreach work carried out by a drug agency, off agency premises, in the community. Some outreach work is 'detached' in that the worker is taking the service to the users, rather than necessarily encouraging them to come to the agency.

Peer education refers to advice-giving by (ex-)drug users to other drug users with a ***harm reduction*** and prevention emphasis. [*See* ***Self-help groups***]

Register of addicts; the annually updated record of addicts who are notified to the Home Office by doctors including those based in hospital and prisons as well as GPs. As it only records cocaine and opioid users, the register should only be used as a guide to trends in the use of those specific drugs rather than an accurate picture of the number of drug users in Britain. Used both for statistical purposes and to enable a doctor to check whether a patient is receving treatment for dependence problems elsewhere. Confidential; information not available to police or other agencies.

Relapse prevention is a form of therapeutic rehabilitation which aims to help people avoid returning to uncontrolled drug use. Patients are rehearsed in how to cope with 'tempting' situations and how to minimise drug use if they do 'lapse' occasionally.

Self-help group is a group in which participants support each other through recovery from drug use. The most well-known self-help group in the drugs field is Narcotics Anonymous. [*See* ***Twelve-step programme/group/method***, ***Minnesota Model***]

Supply reduction describes law enforcement strategies targeted at curtailing drug production and distribution. [*See* ***Demand reduction*** *and* ***Harm reduction***]

Therapeutic communities (often known as 'rehabs') are places where people with drug-related problems try to work through these prior to returning to the community. They tend to be highly structured, run by ex-drug users and geographically isolated.

Twelve-step programme/group/ method is a ***self-help group*** based around the Minnesota Model (so called because it originated in Minnesota) devised by Alcoholics Anonymous. The twelve steps involve the user admitting powerlessness over their life and drug use, surrendering to a 'higher power', making up for past wrongs and offering to help other 'addicts'.

Who killed the British system?

Forced through the health services market to close his drug dependence clinic, John Marks fires his parting shot at the doctors he accuses of having dismantled the 'British system'.

THE BRITISH SYSTEM OF drug control (circa 1920-1971, institutionalised in the 1926 Rolleston report) is a beacon to those across the world struggling with the effects of prohibition. As wars usually do, 'Drug Wars' mounted to shore up unrealistic prohibitions bring ever increasing loss of control while the criminal and financial burdens on the state and its citizens spiral upward and threaten the liberal societies of the West.[1] The moral is that if society wants to control a commodity, it must possess a legal supply of that commodity – for he who controls the supply controls the market.

The British Misuse of Drugs Act provides for the supply of heroin and cocaine to addicts, but this rarely happens in practice. Despite there being over 100 psychiatrists licensed to prescribe heroin for addiction, only a handful do so. The rest, obeying 'guidelines', instead allow criminals to supply the drugs and control the market. Further down the chain, pyramid-selling by drug users to raise the inflated cost of their drugs speeds the spread of drug use. For too long, government and public have mistaken prohibition for control when the opposite is the case.

Who is responsible for this retreat from a humane and successful policy? The blame lies with some leading London psychiatrists, who have consistently advised government that drugtakers cannot be maintained indefinitely on heroin, cocaine, or other drugs – or that, even if they can, this is undesirable. Contradictory facts[2] have made no impression on their views.

Their power derives from huge research staff resources and access to central institutions such as government, the Royal College of Psychiatrists, and leading journals. Only through strenuous efforts can peripheral psychiatrists overcome the inertia of bureaucracies which all too easily turn for their advice to 'in house' (ie, London) experts. Their partisanship is clear in the diatribes[3] and vitriolic invective[4] quoted by North Cheshire Health Authority as grounds for removing the drug dependency contract from our own NHS trust.

> Everywhere government is faced with acolytes of the London view

The policy rethink spurred by AIDS led to a partial rehabilitation of 'maintenance therapy' (a key plank of the old British system), especially in districts far to the north of Watford. In a fierce rearguard action, London doctors emasculated the revival by restricting it to methadone syrup, whose effects one addict likened to "kissing your sister". Methadone helps those who take it, but has almost no appeal for injectors – witness the popularity of needle exchanges.

It might be argued that since around 60 per cent of addicts entering treatment inject, methadone must hold some attractions. But probably just one in seven addicts are in treatment[5] so the great majority are not drawn by what's on offer. The upshot is that injectors continue to be given clean equipment to inject adulterated drugs.[6]

London's dominance over the training of a generation of doctors has imbued most with false premises, such as the idea that tolerance inevitably leads to continued escalation in the doses taken by opiate addicts.[7] The effect has been to replicate the views of London psychiatrists and give these the status of an unquestioned consensus. Officials seeking expert advice sedulously overlook dissenting voices; wherever it turns, government is faced with acolytes of the London view. The only remedy is to seek out and heed critics of current policy.[8]

Many of the most vociferous critics of the Drug War are police. The failures of the medical profession mean drug control has defaulted to police who see first hand the futility of prohibition, a policy one officer described as "criminal".[9] As penalties for consensual crimes are desperately increased, police face citizens who want to use drugs, but who know that if they are caught the punishment will be disproportionately severe. Life imprisonment for drug supply is likely to make not just career dealers but also some addicts (almost all deal to finance their habits) increasingly determined to resist arrest, sometimes violently. It is neither sensible to deploy police resources in this way nor fair to place officers at such gratuitous risk.

It is not too late to revive the British system. But quick and resolute government action is required to avoid the final murder of the 'British System' and total urban drug warfare à l'Amerique.

from
John Marks

The author is the consultant psychiatrist who helped establish Mersey's harm reduction policy in the 1980s. He is a member of the executive committee of the addiction section of the Royal College of Psychiatrists

In the next issue: London-based consultant psychiatrist hits back

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Available from HMSO.

❑ **TACKLING DRUGS TOGETHER: A STRATEGY FOR ENGLAND 1995-1998.** UK Government. London: HMSO, 1995. viii, 68 pages. Report. £7.00.
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Available from Trafford CDT, Chapel Road, Sale, Trafford M33 1FD, phone 0161 962 8810.

❑ **SKINUP AND YOU'RE OFF! DRUGS AND FOOTBALL.** Booklet.
SAFER DANCING: POPPERS. Postcard.
❑ **SAFER DANCING (ANOTHER DOSE WITH KNOBS ON).** Poster.
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❑ **THE VIRUSES: INJECTOR'S QUIZ.** Cartoon format.
❑ **THE DRUG LAWS: WITH PEANUT PETE.** Cartoon format.
❑ **THE DRUG LAWS.** Poster.
Various prices.
Contact Lifeline, 101-103 Oldham Street, Manchester M4 1LW, phone 0161 839 2054, fax 0161 834 5903 for availability.

Counselling/treatment

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Available through bookshops.

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❑ **WHAT THE PEOPLE SAY: EXPLORATIVE RESEARCH AND USER EVALUATION OF THE NEEDLE EXCHANGE SCHEME.** Stephen Law. Norwich: Bure Centre, 1995. 61 pages. Report. £7.50.
Available from the Bure Centre, 7 Unthank Road, Norwich NR2 2PA, phone 0603 667955

History/politics

❑ **DRUGS, CRIME AND CRIMINAL JUSTICE. VOL 1: HISTORIES AND USE, THEORIES AND DEBATES; VOLUME II: CULTURES AND MARKETS, CRIME AND CRIMINAL JUSTICE.** Nigel South *ed.* Aldershot: Dartmouth, 1995. 563 pages and 530 pages respectively. Books. £150.
Available through bookshops.

❑ **DRUGS AND NARCOTICS IN HISTORY.** Roy Porter & Mikulas Teich *eds.* Cambridge: CUP, 1995. xii, 227 pages. Book. £30.
Available through bookshops.

Other

❑ **ECSTASY DEATHS AND OTHER FATALITIES RELATED TO DANCE DRUGS AND RAVING. SUMMARY OF UK DRUG PREVALENCE SURVEYS .....** Russell Newçombe. Free.
Available from 3-D Research Bureau, 25 Halkyn Avenue, Liverpool L17 2AH, phone 0151 733 9550.

❑ **POT NIGHT.** Derek Jones *ed.* London: Channel 4 Television, 1995. 36 pages. Booklet. £3.95.
Available from Pot Night, PO Box 4000, London W3 6XJ.

❑ **SELF-REPORTED DRUG MISUSE IN ENGLAND AND WALES: FINDINGS FROM THE 1992 BRITISH CRIME SURVEY.** Joy Mott & Catriona Mirrlees-Black. London: Home Office, 1995. ix, 67 pages.
Available from Home Office Research and Planning Unit, 50 Queen Anne's Gate, London SW1H 9AT.

❑ **THE STEEL DRUG: COCAINE AND CRACK IN PERSPECTIVE. SECOND EDITION.** Patricia G. Erickson *et al.* New York (etc): Lexington, 1994. xvi, 284 pages. Book. £25.
Available through bookshops.

❑ **STREET DRUGS.** Andrew Tyler. London: Hodder and Stoughton, 1995. 518 pages. Book. £6.99.
Available from ISDD.

MEETINGS

❑ **SECOND EUROPEAN METHADONE CONFERENCE: THERAPEUTIC RESULTS AND SOCIAL RESISTANCE.** 27 September-1 October 1995. Cannes-St Tropez.
Details from Dr M Reisinger, European Methadone Association, 27 rue de la Vanne, 1050 Brussels Belgium, phone/fax 00 322 640 46 28.

❑ **TRICK OR TREAT? THE USE OF SUBSTITUTE DRUGS IN ADDICTION.** 19-20 October 1995. Brighton.
Details from Dr Andrew Johns or Mrs Angela Butler, Division of Addictive Behaviour, St. George's Hospital Medical School, Cranmer Terrace, London SW17 0RE, phone 0181 725 1459, fax 0181 725 2914.

❑ **NINTH INTERNATIONAL CONFERENCE ON DRUG POLICY REFORM. HARM REDUCTION: BRINGING THE INTERNATIONAL COMMUNITY TOGETHER.** 18-21 October 1995. Santa Monica, California.
Details from Whitney A. Taylor, The Drug Policy Foundation, 4455 Connecticut Avenue, NW, Ste. B-500, Washington, DC 20008-2302, phone 00 202 537 5005, fax 00 202 537 3007, CompuServe 76546, 215.

❑ **POLICE-COMMUNITY PARTNERSHIPS.** 14-16 November 1995. Leeds.
Details from Ms Rosemary Shapley, Department of Continuing Professional Education, Continuing Education Building, Springfield Mount, Leeds LS2 9NG, phone 0113 233 3226, fax 0113 233 3240.

❑ **4TH NATIONAL CONFERENCE ON DRUGS AND AIDS.** 14-15 Dec. 1995. Edinburgh. £90 (Addictions Forum members), £110 (non-members).
Details from Peter S.B. Niven, Conference Executive, Addictions Forum, UnivEd Technologies Ltd., Freepost, Edinburgh EH8 0LL, phone 0131 650 3475, fax 0131 650 3474.

COURSES

❑ **RESPONDING TO YOUNG WOMEN.** London. 25 September 1995. £20.
❑ **RESPONSES TO THE GREEN PAPER.** London. 11 December 1995. £20.
Details from DAWN, c/o GLAAS, 30-31 Great Sutton Street, London EC1V 0DX, phone 0171 253 6221, fax 0171 250 1627.

❑ **THE INTERACTION OF SUBSTANCE MISUSE AND SEXUAL ABUSE IN RECOVERING WOMEN.** London. 13-14 October 1995. £50.
Details from Rosa Della-Tolla, The Renewal Trust, 23 Turret Grove, London SW4 0ES, phone/fax 0171 720 0599.

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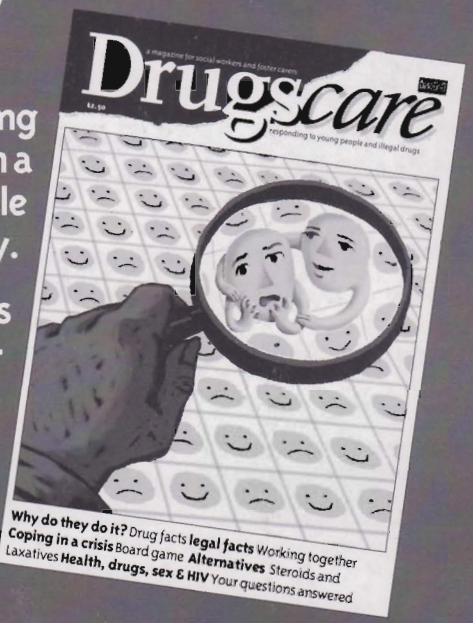

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